District Nursing

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District Nursing

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Editorial

DISTRICT nursing centres are the training ground of the future administrators of the district nursing service. The post of assistant superintendent of a training home or non-training centre is a natural stepping-stone to higher responsibility and executive rank.

Nevertheless these posts are becoming extremely difficult to fill. At the moment there are sixteen vacancies out of a total of one hundred and four available posts. Of these there are six vacancies amongst twenty-eight posts in the London area, and ten in seventy-six posts available in the county and non-county boroughs.

By comparison appointments as assistant county superintendents, for which there are currently five vacancies out of one hundred and twenty-three posts, can be made easily and quickly.

What is the reason for the shortage? What dissuades potential candidates from trying to increase their experience by applying for appointments as an assistant superintendent?

Is it primarily a matter of preference for non-resident posts, in spite of the high cost of living compared with the rate of £173 to £176 per annum charged for full residential accommodation? Does the suggestion of residence provoke fears of too much red tape and unnecessary restriction surrounding off-duty hours?

Alternatively the fault may lie with the job. Does it carry sufficient responsibility with opportunity for assistant superintendents, who have often already held administrative posts in hospital, to use their knowledge and initiative? As preparation for more senior posts to follow, do they attend committee meetings? Are they encouraged to serve on committees of other organisations and have outside interests?

Finally we are wondering whether the introduction of a short course in administration might help? Would this means of preparation for the work of assistant superintendent encourage more applications?

To find remedies we must first diagnose the cause, and that is where we seek the help of readers. We cordially invite readers, both district nurses and employing authorities, to send us their frank comments and views.

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"An extension of this scheme would lighten the work of hospitals and nurses and give relief to countless sufferers"

Taking Physiotherapy into the Home

by KATHLEEN WARD, S.R.N., M.C.S.P.

FOR many years East Sussex has been faced with a difficult problem. How could much needed physiotherapy be given to the home-bound patient, particularly those in the rural areas who could not afford private treatment?

An attempt to solve the problem was made when clinics, financed and staffed by the Sussex County Hospital in Brighton, were set up in some rural areas, but these only dealt with ambulant patients.

The coming of the national health service with the comprehensive and excellent hospital car service helped to a certain extent, but by no means solved the whole problem. There still remained the patient who was too ill to stand transport, and also the patient in the extreme rural areas: cases in which the very long journey and hospital waiting time neutralised any good that treatment might offer.

Another factor which militated against early, and therefore efficient treatment, was the fact that physiotherapy under the national health service could only be prescribed by a consultant. Overcrowded departments and long waiting lists often resulted in a considerable waste of time before even an appointment with a consultant could be arranged. Sometimes a matter of weeks elapsed and what had been a slight disorder became an almost chronic disability.

As a result of discussion between the superintendent of Queen's nurses and the superintendent of one of the largest physiotherapy departments in East Sussex, to whom these matters were a cause of deep concern, a committee was formed to consider what steps could be taken to make physiotherapy available to those who were not able to benefit from either hospital or private treatment.

After careful consideration it was decided that if a small van could be bought and equipped with modern physiotherapeutic apparatus, it could be driven by a chartered physiotherapist. He could then give treatment to patients in their homes under the direction of a general practitioner, at either a very small cost or, in some cases, free. The scheme would, however, have to be financed largely by voluntary effort.

A well attended meeting was held at which the scheme was explained to influential local residents. Such was its appeal that on the same afternoon a van and equipment was promised and it was decided to start a pilot scheme in the Haywards Heath area. The money for the maintenance, salary of a chartered physiotherapist, and general running expenses was the responsibility of a local committee, but a central committee was formed for the purpose of formulating policy.

This comprised:

(1) Representatives of the East Sussex County Nursing Association,
(2) A chartered physiotherapist,
(3) Representatives of local areas (it was anticipated that there would soon be more than one area),
(4) Co-opted members of various interested bodies.

We hoped that local areas would form their own committees on widely representative lines.

It was decided that the name of the service should be ' The Home Physiotherapy Service '.

We were very fortunate in obtaining the services of a first-rate physiotherapist, and in 1948 the service began. Our first van took the road and proved an immediate success. Requests for treatment poured in, and it was soon obvious that to meet the numerous requirements of doctors and patients more vans were needed. Gradually a fleet was built up and now in 1958 seven vans are on the road and the whole of East Sussex is divided into six areas. Each has it's own committee.

It is not easy to condense into a few words the effort and enthusiasm which went to finding the money to provide, equip and maintain seven vans.

Since 1948 the East Sussex Home Physiotherapy Service has built up a fleet of seven specially equipped vans

Patient's fees, which must not exceed 7*s* 6*d*, and which average 3*s*, account for about a quarter of the cost of running each van.

In 1949 the South-East Metropolitan Regional Board, recognising the usefulness of our scheme, undertook to pay the cost of any treatment ordered by a consultant. The amount from this source varies in each area.

The difference between the money thus raised and the cost of each treatment (now just under 12*s*) is raised by the local committees' efforts—bazaars, penny-a-week schemes, sale of milk bottle tops.

To be eligible for treatment the patient's doctor must consider that he will derive greater benefit from home than hospital treatment, though he need not necessarily be bed-fast. The patient must not be in a position to obtain treatment from a private practitioner. This is sometimes rather difficult to assess but with the doctor's and nurse's help there is very little evidence that the service is being abused.

Participation in the service is not open to those living in the county boroughs, but in the smaller towns such as Lewes and Haywards Heath it works in exactly the same way as in the rural areas.

At the headquarters in Lewes a part-time secretary acts as liaison between members of area committees and the central committee. It is her duty to order vans and equipment, arrange various insurance policies, to render accounts to the hospital board and to be generally responsible to the central committee.

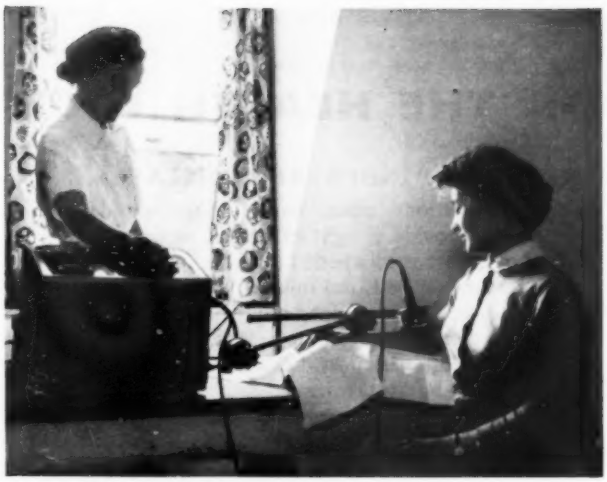
Records of all treatments, van mileage, etc., are kept by the physiotherapists and after being seen by the local committee are forwarded to the office monthly for submission to the central committee at its meetings.

Scope for Initiative

For the physiotherapists it is an exacting but most rewarding and interesting job, giving scope for endless initiative and also time for thorough and worthwhile treatment. Each works alone but all meet every two months to discuss items of common interest. They are given ample leave for post-graduate work and keep themselves up to date and ready to meet the endless and varied calls upon their skill and time.

Because of the responsibility of their work they have to have at least two years' previous experience and the service has been most fortunate in attracting excellent members of the Chartered Society of Physiotherapy. Only one male physiotherapist is employed at this time but this is not in any sense a rule. No preference has been encountered amongst either doctors or patients, though the only area running two vans has the services of one male and one female physiotherapist.

Co-operation with the Queen's nurses has been extremely helpful. Frequently it is the nurse who calls the attention of the doctor to the possibility of physiotherapy for her patient. In this way cases are often treated at an early stage of their disability enabling a far better result to be obtained.



A female physiotherapist gives a patient treatment in her home from portable short wave equipment

About 50 per cent of the cases treated could be classed as ' elderly chronic ' (though these are words the physiotherapists are very loath to use) and early treatment has kept many a case from becoming bed-ridden. In other cases patients have been enabled to get up and resume limited activities thus lifting a great nursing burden.

In addition to the work for the elderly which is largely concerned with cerebral disasters and rheumatism in all its forms, we are being called on to treat an increasing number of acute cases. Many can now be treated as out-patients through the home physiotherapy service. Before, they would have had to occupy a hospital bed to obtain treatment. Early skilled treatment at home is also able to avoid later hospitalisation.

It has been argued that domiciliary physiotherapy is an expensive way of using members of the Chartered Society, who are in short supply, but in practice the number of treatments given to a patient early in his home where the physiotherapist can assess his needs in his own surroundings, is often considerably fewer than the number required if given later in hospital.

Prices have varied over the years. At present it costs roughly £1,100 to buy and equip a van and run it for one year. The effort needed to raise this money is amply repaid when the amount of pain and disability that has been relieved in East Sussex during the past ten years is considered. A further extension of this scheme would do much to lighten the work of hospitals and nurses and give relief to countless sufferers.

The vans used are six cwt. ' Standard ' vans with the interiors specially fitted to hold the following apparatus: radiant heat and infra-red lamp, short-wave diathermy, ultra-violet light, wax, galvanism, faradism, cautery and Guthrie-Smith slings, etc., for full suspension together with walking frames, crutches and tripod sticks.

ON THE HEALTH FRONT

PRESCRIBED INDUSTRIAL DISEASES

NEW regulations which came into force on 5th January provide a right of appeal against medical boards' decisions as to whether or not someone claiming benefit under the industrial injuries scheme, is suffering from one of certain prescribed industrial diseases.

Appeals by claimants will be decided by medical appeal tribunals. They will also consider decisions referred to them at the instance of the Minister of Pensions and National Insurance. The tribunals, each consisting of doctors of consultant status with a legal chairman, already consider appeals against medical boards' assessments of the extent of disablement due to an industrial accident or disease.

POLIO VACCINE PIONEER'S VISIT

DR. Jonas E. Salk, discoverer of the polio vaccine which bears his name, heads the list of distinguished international health figures who will address the annual congress of the Royal Society of Health, to be held at Harrogate from 27th April to 1st May.

Over sixty papers and addresses, touching on every aspect of public health, will be delivered at the congress, which is expected to be the " biggest-ever " held by the Society. Sir Ernest Rock Carling, formerly chairman of the International Commission on Radiological Protection, will preside over a new section devoted to radiation.

Speakers from America include Professor Philip Drinker of Harvard University, in the preventive medicine section, and Dr. G. M. Fair, also of Harvard, who will give the Chadwick Lecture on *New Factors in Man's Management of his Environment.*

Educational visits to places of public health interest, and a health exhibition, are being arranged in conjunction with the congress.

THE CHEST AND HEART ASSOCIATION

THE National Association for the Prevention of Tuberculosis will in future be known as The Chest and Heart Association.

No change of policy is involved. The conquest of tuberculosis in all its forms will remain the Association's primary concern. At the same time, attention will be turned to prevention, research and education in chronic bronchitis, lung cancer, asthma, and diseases of the heart.

FILM STRIPS FOR DISCUSSION

THE Central Council for Health Education has recently produced four film strips to stimulate thought and discussion among people in every walk of life, on situations which can arise in any family and which affect mental and physical health. Each strip presents a problem, and ends by posing a question to promote discussion.

The strips consist of a series of 35 mm. stills. An interesting feature is the sound, which is provided by gramophone records. These may be played on an ordinary gramophone, although the best results are obtained with an electric gramophone, with the loud speaker placed near the screen.

The titles are: Habit Training (potting the baby); Choosing a Career (for boys and girls); For Better for Worse (marriage guidance); and That Time of Life (change of life and cancer fears).

Sets (filmstrip with record) may be bought or hired from the Central Council for Health Education as follows: subscribers—35*s* per set (hire 10*s* per week); other—50*s* per set (hire 15*s* per week).

R.S.H. FELLOWSHIPS

THE Royal Society of Health has conferred Fellowships upon the following, in recognition of their noteworthy public health work: Dr. R. W. Elliott, M.O.H., Bolton; Dr. M. S. Harvey, M.O.H., Canterbury; Miss P. E. O'Connell, H.V. Tutor, Southampton University; Dr. W. P. Phillips, M.O.H., Cardiff; and Dr. M. I. Silverton, M.O.H., Rye and Battle.

ADVANCE IN ENEMA THERAPY

HARKER'S Disposable Enema is claimed by the makers to reduce this time-consuming and uncomfortable operation to a process which is rapid and acceptable to the patient.

The efficiency of phosphate solutions as enemas was established by Page *et al* (*J.A.M.A.* 1955, p. 1208). It has been confirmed by a hospital specialising in diseases of the rectum and by the maternity department of a large teaching hospital, both using Harker's.

Advantages of the disposable enema include the time element—10–15 minutes for administration; the absence of danger from cross infection; and, of particular appeal to the district nurse, its compactness which does away with the need for bulky equipment.

SAFETY BARS FOR THE NURSERY

PARENTS of young children, and particularly those living in flats, will be interested in a new design of safety bars which will be on show at the Brighton Toy Fair in February. The bars, 22 inches long, are manufactured from steel rounds and heavily chromium plated. They come in sets of four complete with eight wood screws.

The manufacturers are the Wearwell Cycle Co. Ltd., Wolverhampton.

The district nurse should teach old people to help themselves and instruct relatives in the ways that they can assist

The Elderly and Chronic Sick

by C. A. BOUCHER, O.B.E., M.A., D.M.

AN ageing population is not a condition peculiar to this country for in most countries of Western Europe a similar picture can be drawn. In Britain the number of old people and their proportion to the rest of the population are greater than ever before; the proportion of old people to children in the population is greater than ever before; and those of working age are increasingly middle-aged. The position has resulted from better living and social conditions and from advances in medical treatment and in the prevention of disease.

Since the end of the last century there has been a decline in the birth rate and an increase in the expectation of life. A male child born today can expect to live sixty-eight years, and a female child seventy-three years. There is no doubt that when medical science is able to conquer the diseases of middle age, such as cancer or coronary thrombosis, the number and proportion of old people will increase further.

The question whether we are going to become a nation of centenarians is often asked. It should, however, be remembered that over the last hundred years there has been little increase in the expectation of life of those persons who have reached sixty-five years. What is happening is that more individuals are reaching old age, including the frail and the infirm who are surviving the hazards of middle age, but from that point they can expect to live little longer than did their parents or grandparents.

The Royal Commission on population has estimated that in the next two decades there will be more old people with less young people to support them. The problem may be aggravated by smaller families, continuing employment of women, dispersal of family groups, and an attitude of mind which calls for total state responsibility for dependants.

Medicine has established a remarkable control over acute disease during the present century, but progress in the prevention and the treatment of degenerative disease has been slow. The amount of ill health among the aged is considerable, and the fear of ill health in those growing older can cause great unhappiness.

Local surveys suggest that ten per cent of old people at home are housebound or bedfast. Many live in conditions unsuitable and isolated, for their homes may be too big, the stairs may prove an impassable barrier, while water and toilet facilities may be too remote. Such conditions can lead to loneliness and a feeling of neglect, with resulting mental and physical ill health. It is significant that one quarter of the men in employment retire before the age of sixty-five years on the grounds of ill health.

There are no constant pathological changes in the ageing process but "old age" was defined to the Phillips Committee in the following words:—

"The state of old age is that in which the physical and mental independence of adult life becomes so compromised that there is definite limitation of activity and at the same time absence of disease."

If this definition is accepted then signs of old age usually begin to appear in the early seventies. Old age is really a meaningless term, for its evidence depends much on the state of mind of the individual, and most old people lead useful and contented lives. Our concern is with those who make special demands on our services, particularly those living alone or with one younger relative who is bearing the whole load.

Ministry of Health Survey

A few years ago the Ministry of Health carried out a survey throughout England and Wales of the services available to the chronic sick and elderly. A report of this survey was published and was followed by a memorandum to hospitals and a circular to local authorities.

The Minister of Health supports fully the recommendation of the Guillebaud Committee which states: "The first aim should be to make adequate provision wherever possible for the treatment and care of old people in their homes." This, of course, means that great and increasing demands are made on the services of the general practitioner, the district nurse, the home help and the voluntary organisations.

A general practitioner has reported that the average number of attendances on his patients each year is 3.2, but this figure rises to 4.1 for patients aged sixty to sixty-nine years, 7.0 for those aged seventy to seventy-nine years and 7.7 for those aged eighty years or more. Sixty-two per cent of people assisted by home helps are chronic sick, or the aged and infirm. Forty-five per cent of the visits paid by district nurses are to elderly patients. An increasing proportion of hospital beds is occupied by elderly patients. Half of the medical in-patients at the Edgware general hospital are aged sixty years or more, and in one hospital region thirty-eight per cent of the beds, excluding chronic sick beds and mater-

nity beds, are occupied by patients of this age group. Twenty per cent of admissions to mental hospitals, and thirty per cent of their in-patients are aged sixty-five years or more.

A heavy burden falls on the district nurse. In 1957 district nurses in England and Wales paid twelve-and-a-half million visits to elderly patients. The requests for their services came largely from general practitioners. A district nurse may have to work under difficult and, sometimes, even repellent conditions. She treats elderly patients whose illness may be complicated by social breakdown. She is concerned with chronic sick patients who should be in hospital or perhaps may appear to have been discharged too early from hospital. Some may be mentally confused and unable to co-operate.

In a recent survey in Camberwell and Lewisham of households with older people needing the services of a district nurse and/or a home help, it was reported that one-third of the people needed daily nursing, and that thirteen per cent of the men and twenty-one per cent of the women were bedridden. Like the general practitioner she strives to maintain the health of her patients at home for as long as possible, for they want to remain at home and institutional care is often difficult to obtain.

The district nurse often appears to be working in isolation, and I believe that there is a need for greater liaison with the other services and particularly a closer link with the hospitals. The district nurse should not attempt to relieve all old people of all their responsibilities. She should rather regard it as her responsibility to teach old people to help themselves and to instruct their relatives in what ways they can help. It is understandable that sometimes the district nurse may appear to devote too much attention to individual old people, but this can embarrass the service.

Some of her work appears to be concerned only with minor disabilities which do not always need her skilled experience, and there is a case, I think, for the introduction of nursing auxiliaries who would operate under the supervision of their trained colleagues. The instruction of old people in the use of gadgets and other loaned nursing equipment will also be an expanding feature of her work.

Restoring Independence

The geriatric physician in hospital, and the district nurse at home, are showing how the aged sick can be restored to independence. Increasingly in the future we need to think more of preventive measures and health education. The district nurse, in view of her status and prestige, can contribute much to the maintenance of health and harmony in the home; to take one example, the prevention of accidents. Three-quarters of the fatal home accidents involve elderly people over sixty-five years of age, and more than half those are over seventy-five years of age.

Accident proneness increases with age, and one-third of the accident beds in hospitals are occupied by elderly patients. Failing senses of vision, hearing and smell, accompanied by forgetfulness and infirmity, undoubtedly predispose old people towards accidents. They are especially vulnerable to falls, coal gas poisoning, burns and scalds. The district nurse can play an important part in the prevention of home accidents.

Undoubtedly the district nurse is saving hospital beds and is relieving hospitals by preparing patients at home for various diagnostic measures arranged at hospitals. I feel sure that an increase in institutional beds alone will not solve the problems created by an ageing population.

The key to success is the efficiency of the home services to give assistance when needed and to prevent disability, and to retard the progress of degenerative disease. Among these various home services the district nurse has a most important part to play. In a recent number of " The Practitioner " it was stated that " No hospital geriatric service can be really effective unless it is run as a safety valve for a service mainly of home care ".

The national survey of the services available to the chronic sick and elderly repeatedly drew attention to the valuable contribution made by the district nursing service. The maintenance of the district nursing service in the London area involves much careful organisation, and this service from all accounts is very good. Great credit is due to the sympathetic attitude of the county council and the local voluntary associations. One hears the highest praise of this service without which the care of the elderly sick would undoubtedly break down.

(From a lecture to the Central Council for District Nursing in London)

Can You Cook?

CENTENARY COOKERY BOOK

We'll welcome recipes galore
of meat and fish and soup and sauces
of every kind for savoury courses.
In fact we'll need to have a lot
of scones and pastries, fritters hot,
of pickles, chutney–roasted ham,
of curry, souffles, cakes and jam.
By publishing your favourite meal
you're helping us in our appeal.

To help the centenary appeal of the Queen's Institute of District Nursing, the Association of Queen's Nurses is to publish a special cookery book. If you can cook, please send your favourites together with half-a-crown for each one towards the cost of printing. Your name and address, unless you request otherwise, will be printed with your recipes in the book. All profits from the sale of the book will go to the centenary appeal.

If you cannot cook, ask your friends to send their favourite recipes.

Recipes and postal orders or cheques should be sent *not later than the 30th April, 1959*, to Miss N. M. Dixon, Chairman of the Association of Queen's Nurses, 144 Holly Lodge Mansions, Highgate, London. N.6.

Equipment with drugs and the knowledge of how best to use them gives the midwife the feeling of safety necessary for the satisfactory practice of domiciliary midwifery

Drugs and Domiciliary Midwifery

by MARGARET D. DOWN, S.R.N., S.C.M., M.T.D.
Supervisor of Midwives, County Borough of Ipswich

WE are living in an age of speed and in keeping with all else new drugs appear on the market almost daily. Some come to stay, others disappear—if not for good their popularity wanes.

It is therefore as well from time to time to look at the drugs used in domiciliary midwifery practice, for it is better to have a few well tried drugs which the midwife thoroughly understands from repeated use than a crowd of drugs which are used infrequently and whose value is never appreciated.

To practise domiciliary midwifery satisfactorily a midwife must be given a feeling of safety. This can only be achieved by equipping her with the necessary drugs and equipment and the knowledge to use them to the best advantage.

The drugs carried may vary from area to area, and to some extent they depend upon the distance of the midwife from the general practitioner or hospital. The midwife in a rural area usually needs more drugs than her colleague in urban districts.

In the area in which I work we have an excellent link with the general practitioner and the maternity unit attached to the general hospital. They are always willing to help in any emergency or to give advice when needed.

A midwife's practice no longer begins at the onset of labour and finishes at the tenth day of the puerperium. She is responsible for the care of the mother throughout the ante-natal period; during the labour; and for at least fourteen days of the puerperium and preferably twenty-eight days.

In this she is of course helped by the general practitioner and any other members of the team necessary for the well-being of mother and baby. Evidence of her good work is seen daily in the healthy mothers and babies of the country; and of her not so successful work in the mothers and babies left, as the result of childbirth, mentally or physically handicapped.

Many things play a part in bringing childbearing to a satisfactory conclusion. The use of drugs is only one contributory factor, but rarely can we satisfactorily get through without the help of these invaluable additions.

A drug is any substance taken into the body or applied to its surface for the prevention or treatment of disease. The following is a list of those useful in domiciliary practice.

THE ANTE-NATAL PERIOD

For the treatment of early morning sickness after all simple methods have failed:—

1. **Dilute Hydrochloric Acid.** 5 drams to an eight ounce bottle of water. One teaspoonful before meals.
2. **Avomine.** 2 tablets at night.
3. **Ancoloxin.** 2 tablets at night.
4. **Dramamine.** 2 tablets at night.

Remember what suits one patient fails in another and it is often necessary to try more than one.

IRON DEFICIENCY ANAEMIA

As the result of hydraemia the Hb. level of the blood always falls slightly. In addition the demands of the foetus are increasing throughout pregnancy and as a result of several factors the absorption of iron may be affected, in spite of diet being adequate.

It is the right of every expectant mother to have her Hb. estimated. This is the only way to determine the true extent of any iron deficiency which may exist. This should be done at the first visit. If normal, then again at 32 weeks and 36 weeks. If low at the first attendance, at monthly intervals until within normal limits.

Various forms of iron are available, and it is often necessary to try more than one to find the iron with the right additional factor:—

1. **Ferri-Redoxon. tablets.** Iron + Vitamin C. 2 T.D.S.
2. **Ferramyn B tablets.** Iron + Vitamin B and other factors. 2 T.D.S.
3. **Ferraplex B tablets.** Iron + Vitamin B and other factors. 2 T.D.S.
4. **Colliron.** Liquid iron. Half teaspoonful T.D.S.

If the Hb. fails to rise, or falls to a serious level it may be necessary to administer intra-muscular iron. For this ' Imferon ' seems very popular. It is necessary to follow the directions carefully when giving this to avoid staining of the skin.

Even with a normal Hb. at the onset of pregnancy it is difficult to meet the demands of the foetus without giving some routine iron. For this Ferri-sulphate tablet j T.D.S. is usually satisfactory.

Intolerance to iron produces abdominal pain, diarrhoea and vomiting.

SLEEPLESSNESS

A number of patients find sleeping towards the end of pregnancy difficult. Many respond to the giving of calcium. This may be psychological, or perhaps sleeplessness is bound up with calcium deficiency. At any rate it is worth a trial. If this fails:—

1. **Noludar tablets.** 1–2 at night. Leaves no after effects.
2. **Sodium Amytal capsules.** gr. j–iij at night.

PREGNANCY NEURITIS

Vitamin B by mouth. 4 Aluzyme tablets 3 times daily.

HEARTBURN

A real worry to the mother. She often stops eating various foods and her diet can get deficient. As it is caused by relaxation of the cardiac oriface and the regurgitation of food into the lower end of the oesophagus, we find here that dilute hydrochloric acid, as used for early morning sickness, nearly always cures the condition.

Droxalin tablets. One after each meal for those who fail to respond to the hydrochloric acid.

Never forget to see that the expectant mother knows about the dangers of taking Soda Bicarb. in pregnancy for heartburn. It can cause retention of fluid and all the dangers that go with it.

Cramp. 2 x gr. Calcium Lactate tablets T.D.S.

Vitamin K. Synkavit 10 mgm. daily in the last two weeks of pregnancy:—

(*a*) when the mother, at any time during her life, has had bleeding during dental extractions;
(*b*) if post partum haemorrhage has occurred in previous labours;
(*c*) where a condition such as cerebral haemorrhage has occurred in a previous baby.

INDUCTION OF LABOUR

In my opinion any induction other than the simple Castor Oil, bath, and enema should be carried out in hospital.

Stilboestrol. 25 mg. at 2 hourly intervals until 125 mg. have been given is our usual method here.

Pitocin. By intravenous drip method. 2 units half hourly up to 2 c.c. or until contractions start.

Pitocin is a dangerous drug and at any moment may cause a tonic contraction of the uterus and the death of the baby. Therefore it should be given by a **doctor only** and the doctor should remain with the patient until completion of the induction.

LABOUR

The less drugs used the better during the 1st and 2nd stages. Correct teaching during the ante-natal period will often help considerably.

Sedatives. **Syrup of Chloral** drachms iij or
Weldorm tablets. 2–3 tablets (= drachms ij–iij Syrup of Chloral). Much less nauseating for the patient and much easier for the midwife to carry. They are very popular with my staff.

Oblivon. A useful tranquilizer for the very nervous patient. 2 capsules per rectum after the rectum has been emptied.

Pethilorfan. = (Pethidine 100 mgm. / Lorfan 1.25 mgm.) made up in 2 c.c. ampoules

A dangerous drug needing careful handling, but very useful with its sedative and antispasmodic action. Given when labour is well established or when there is any rigidity of the cervix.

The lorfan reduces the depressing effect on the respiratory centre of the baby. 100 mgm. of Pethidine is the usual dose, repeated once if necessary, but many patients do well on 50 mgm. We find best results when given with 2 Weldorm tablets.

For the mother with the tedious labour and considerable back-ache with the posterior position " Mothers Mist " is still very useful.

Syrup of Chloral	M. 120.
Pot. Brom.	Gr. 30.
Tinct. Opii.	M. 5

Morphia. Gr. ¼. Still a very useful drug for the patient with a long, tedious labour and for the patient with the unexpected eclamptic fit or A.P.H.

A very great pity midwives are not allowed to carry **one** ¼ gr. Morphia particularly those in the very rural areas for the extreme emergency awaiting help.

Sodium Amytal. Gr. iij–vj to induce sleep.

Pill Opii. Gr. i. Rarely used now but very useful for the unexpected A.P.H. and for the odd patient in tedious labour.

Apart from sedatives a midwife will also find the following of assistance:

Ergometrine Maleate. 0.5 mgm. intra-muscularly after the completion of the third stage to ensure good contraction. For the arrest of post partum haemorrhage given with Hyalase 1.500 units for rapid absorption. Can be repeated in ten minutes if necessary.

Ergometrine. 0.25 mgm. can be given intra-venously in a grave emergency if the midwife is used to venal punctures.

Many give Ergometrine at the crowning of the head or the birth of anterior shoulder with the idea of reducing P.P.H. I see no reason for this in normal cases, but should the midwife be left alone it is useful in P.P.H. risks e.g. previous haemorrhage, grand multipara, twins, etc.

Pitocin. 5 units given after the completion of the third stage with severe P.P.H.

Methidrine. 30 mgm. in 1 c.c. Half c.c. given and repeated if necessary in cases of marked fall in blood pressure after giving Pethidine, or in obstetric shock with no haemorrhage.

Trilene.
Gas and Air. } As Analgesias.

If a patient has had Trilene and has to be admitted to hospital where another anaesthetic may be given, we attach a label to the patient. This label has a red cross and black letters stating that Trilene has been given.

Dextran and a "giving set" carried by midwife to be used by the doctor pending the arrival of the Obstetric Flying Squad in a severe P.P.H., always remembering that a small amount of blood must be extracted first for cross matching.

THE LYING-IN PERIOD

Stilboestrol. For suppressing lactation. 15 mgm. after delivery. Then 5 mgm. T.D.S. for 3 days. Then 5 mgm. daily for 3 days.

Ergot tablets. Gr. 2½. 2 twice daily for 2 days.
To promote contractions and help expel any bits of retained membranes.

Quinine Sulphate. Gr. x. To help expel membrane. Given on 2nd evening.
To promote lactation:—

Vitamin E	30 mgm. daily.
Vitamin B	12 Aluzyme tablets daily.
Thyroid	Gr. j daily.
Lugals Iodine	M.v. T.D.S.

FOR THE INFANT

Oxygen with the means to give it intra-gastricly for the severe asphyxia is an absolute **must.**

Vitamin C	For the premature baby give up to 50 mgm. daily
Vitamin A and D	For the premature baby give Adexolin 5 M. daily
Vitamin K	Synkavit 1 mgm. To reduce the chances of haemorrhage in all risk babies.
Syrup of Chloral gr. j **Chloral Suppositories gr. ij**	For cerebral irritation
Loboline	1/20 gr. Occasional use in severe asphyxia.
Cardiazol	1½ gr. Occasional use in severe asphyxia
Coramine	½ c.c. Occasional use in severe asphyxia.

There are many other drugs used including the antibiotics and sulpha drugs which, in a short article like this, I have not attempted to embody. Remember always the C.M.B. rules that a midwife may use only drugs of which she knows the dose and understands their uses.

All drugs, other than a simple aperient, must be entered into her register of cases and all Dangerous Drugs Act drugs in her special D.D.A. book.

PENICILLIN CODE

WARNINGS against indiscriminate use of penicillin have been issued by the World Health Organisation following a comprehensive study of reports on adverse reactions to the drug. The number of these reports has been steadily increasing with the expansion in penicillin production from 29 pounds in 1943, when the drug first came into use, to 750 tons annually.

In relation to this, the number of toxic and allergic reactions has so far been exceedingly small. It is, nevertheless, estimated that by 1957 about 1,000 fatal reactions had occurred in the U.S.A.

At the present time, however, the risk involved in using penicillin is not greater than that involved in the use of many other drugs, and the tremendous good which penicillin is doing in curing diseases and preventing death should not be overlooked.

Simple precautions may prevent some of the serious consequences which now occur. First of all, penicillin should not be used unless prescribed by a physician. In this connection the WHO experts point out that severe penicillin reactions occur after repeated exposure to the drug, and that many cases of severe reactions can be attributed to previous unnecessary use of antibiotics.

Secondly, penicillin should not be used against minor infections such as the common cold, for which it is no more effective than other drugs.

According to the study, patients with a personal or family history of allergy are most likely to develop severe adverse penicillin reactions. In general, reactions are most common in adults between 20 and 49 years of age. They are rare in children under 12, and the frequency decreases rapidly with increasing age after 50.

Another reason for restricting the use of penicillin is the development of resistance to antibiotics in staphylococci. Most strains of staphylococci were susceptible to penicillin when the drug first came into use, but hardy and more resistant strains emerged and have become a menace in hospitals where they sometimes cause deadly epidemics among children and infants.

Bursaries for Teaching Courses

ARE you interested in teaching and have you ever thought of taking the District Nurse Tutor or Health Visitor Tutor Course? If you have, it may be possible to obtain a bursary from the Queen's Institute to enable you to undertake the course beginning in September this year at the Royal College of Nursing.

Two bursaries of £400 each are being offered by the Queen's Institute to nurses on the Queen's Roll who are also State Certified Midwives and qualified Health Visitors. Applicants should have at least three years experience of district nursing or health visiting.

If you are interested write for full details to: The Education Officer, Q.I.D.N., 57 Lr. Belgrave St., S.W.1.

The author prepares to take off in one of the two light aircraft which the Newfoundland Government has made available as air ambulances

From nursing stations such as this at Forteau Village, the International Grenfell Association operates medical and nursing services amongst the scattered fisherfolk of Newfoundland and Labrador.

District Nursing with a Difference

by LESLEY M. DIACK, S.R.N., S.C.M., Q.N. cert.

THE International Grenfell Association operates a medical service over a wide area in Labrador and Northern Newfoundland. The work of this "Grenfell Mission" is carried on among the fisher-folk who live in small primitive settlements scattered along those bleak and rocky shores. The main hospital of 120 beds is at St. Anthony in the north of Newfoundland, and grouped around it at strategic places and distances are the nursing stations, which are like very small cottage hospitals, except that they are staffed only by nurses. Further north, and in the remoter areas are other more ordinary small hospitals, with doctors as well as nurses on the staff.

It is the nursing station nurses who are really the district nurses of the Grenfell Mission; however it is district nursing with a difference. For one thing there are no newspapers! (Except the precious few the nurse has sent out from home) and there are also few of the other ordinary amenities of civilisation. There are few roads, no railways, and though in some parts the nurses are now able to travel their districts by jeep or snow-mobile, in others the winter travel is still done by sled and dog-team, and the summer travel by boat.

Dog-team riding can be lovely when the snow is crisp and sparkling and the "slipping" good and the sun shines out of a clear blue sky. But it is far from lovely in a blizzard at night on an urgent call, or in the spring thaw in the pouring rain when the snow is slush and the sled hardly slips at all. Likewise by boat, it can be lovely when the sun shines on a calm blue sea, perhaps studded with shining ice-bergs; but it can also be grim in storm and wind, but exhilarating, and mainly very rewarding.

The districts covered by the nursing stations vary in size, but average about 75 miles of coast, with from 1,500 to 4,000 people living in anything up to 30 different small hamlets scattered along the shores. Most of the districts are single ones. The double ones are easier to organise, as one of the nurses can always stop home to look after the station leaving the other nurse free to travel. On the single ones it is more difficult.

The nursing stations mostly accommodate ten to twelve in-patients (some more, some less) and there are also dispensaries for treating out-patients. It is to the nursing station that all the local sick people come to be nursed and the maternity patients to be delivered and cared for. On a single district, with such distances and difficulties of transport, it is obviously impossible for the nurse to go out to every case. It has been found more economical of time and personnel to have stations large enough to accommodate all the patients and yet small enough to be run by the one nurse. Local help is always available, and the girls are intelligent and can mostly be trained up to quite a high degree of efficiency.

The stations are all modern and extremely well equipped, with all "mod. cons." including central heating, and each has its own electric light plant. One of the local men is generally employed to look after this and to do the heavy work and to run the boats in the summer. Each station too, is equipped with a radio-telephone, and this is, quite literally, the life-line of the nursing station. Isolated as some of the station nurses are, maybe 80–100 miles away from the nearest hospital or doctor and with transport only possible in good weather, many may be the occasions

When the snow is crisp and sparkling, and the 'slipping' good, visiting by dog sled and dog-team can be exhilarating

when lives may literally be saved by this most modern method of communication.

The main call station is at the hospital at St. Anthony, and from here "skeds" are kept three times a day with every nursing station. Much administrative business is done over the "R.T.", but its main function is to keep the nursing stations in touch with the hospital and for consultation with the doctor. Nowadays there are two small single-engined aircraft which the Newfoundland Government have made available for the medical work, and to act as air ambulances; given good weather and good radio reception, emergencies may be got over to hospital within a matter of hours.

However the weather is by no means always good in the north of Newfoundland, and the station nurse may still be called upon to deal with the emergencies herself. These may be anything: perhaps a pyloric stenosis baby, that with a struggle is kept alive till the plane finally comes several days later to take him to hospital: perhaps a fractured femur to be put up in a Thomas' splint; or a patient in diabetic coma needing almost hourly instructions from the doctor at St. Anthony: anything and everything may have to be dealt with, but worst of all, and ones that won't wait, are the obstetrical emergencies.

With time, of course, one's perspective towards what constitutes an emergency gradually changes; these things are but relative, after all! One of the nurses once remarked to one of the doctors that she had come to recognise only two types of real emergencies; one was an acute abdomen, and the other an ante-partum haemorrhage. To which the doctor replied "With modern antibiotics I would say there was only one, and that is a woman bleeding"!

Ah, well, as British midwives, we should at least know what *ought* to be done.

Practically all the nursing station nurses *are* British midwives.

All the myriad minor ills come the nurse's way, too, to be dealt with in their turn: sick babies and feeding problems: the old people and theirs: indigestion and hypertension: skins and boils and infectious diseases: they're all the same the whole world over, except that in Labrador one never seems to see a varicose ulcer, or arthritis. The nurse is also the local dentist, for extracting teeth, or "hauling" them as the patient perhaps more aptly describes the operation.

The organisation of the work and the district is left entirely to the nurse, though advice, support and help is always available. The doctor probably visits two or three times a year, but on his trip he will travel right through the district. Most station nurses *aim* to get around their districts at least three times a year, but these trips are extraordinarily difficult to organise and fit in. One just has to be prepared to down tools and go the very minute the weather clears. Then the hospital (i.e. station) empties, and we hope that the "stork" will not inconveniently arrive the minute one's back is turned!

As well as the medical, ante-natal and general work, there is also all the public health work to be done on these trips: Triple Toxoiding (i.e. Pertussis, Diphtheria and Tetanus) from three months up, Polio inoculations from six months: follow-ups on patients discharged from hospital. Tuberculosis is one of the major problems. Mass X-ray surveys are done each summer by the Grenfell hospital ship which carries an X-ray machine, but contacts and suspects must be sorted out well ahead. Patients requiring hospital treatment may be discovered and arrangements must be made to get them flown over to St. Anthony. If not too much pressed for time, the nurse may do house-to-house visiting at some of the settlements; many unsuspected cases of

A 'district' consists of about 75 miles of coast along which are scattered up to 30 small, bleak, primitive settlements

NURSING BOOKSHELF

A Handbook of Obstetrics and Gynaecology for Nurses by Douglas G. Wilson Clyne, B.Ch., L.R.C.P., M.R.C.S. (John Wright and Sons Ltd., price 15*s.* postage 10*d.*).

STUDENT nurses and pupil midwives as well as the trained nurse seeking some easily assimilated revision, should find this new book of obstetrics and gynaecology valuable in their studies.

The book has a very orderly arrangement and the information in each chapter is tabulated with a refreshing clarity and simplicity. Starting with the anatomy and physiology of the female generative organs, the author proceeds to demonstrate gynaecological procedures in the ward and out-patient's departments. There follows the aetiology and treatment of gynaecological abnormalities with useful chapters on pre- and post-operative care. Nurses will find the methods and listing of instruments used of great value.

The section of obstetrics is somewhat shorter, with perhaps a little too much emphasis on abnormalities; but the subject is well covered with clear diagrams and, whilst not supplanting the current midwifery text books, will provide a useful adjunct to them for the pupil midwife.

A.E.S.

Bailliere's Midwives' Dictionary (Third Edition) compiled by Vera da Cruz. (Bailliere Tindall and Cox 6*s* 6*d*).

In compiling the third edition of this useful dictionary, Miss da Cruz has given of her ability and experience as a midwife, teacher, author and midwifery examiner. The text has been modernised throughout and extra words and phrases included. The illustrations are clear and well labelled and definitely show what they set out to demonstrate.

The second half of the book contains 31 valuable appendices, including blood and blood transfusions, hormones, jaundice of the newborn child, prematurity and postmaturity, and others of interest to midwives.

The book contains a wealth of information, concisely and clearly set out. It would be invaluable to any midwife or pupil midwife for quick reference. It is a well-bound volume of a useful size to handle easily.

R.A.B.

Lecture Notes on Midwifery by T. F. Redman, F.R.C.S., M.R.C.O.G. (John Wright and Sons Ltd., price 12*s.* 6*d.* plus 8*d.* postage).

THIS small book, written in note form, is intended primarily to form the basis of the course of lectures given by a consultant to Part I pupil midwives.

Although it is easier to retain the individuality and "personal touch" which make for good teaching, when lectures are prepared personally, it is unfortunately true that many consultants have insufficient time for lengthy preparation. They will find this book valuable.

In the small section on home confinement many domiciliary midwives would disagree that the oral drug of choice is "Mothers Mist", preferring chloral hydrate, syrup chloral or chloral hydrate capsules.

On p. 20 "Foetal Circulation" (c) should read "Ductus Verrosus" (not Verosus). In notes on the pelvis, and its dimensions, no mention is made of the sacrocotyloid diameter, although this will be necessary to explain the conversion of an occipito-posterior position into a face presentation; and, although the incidence of Rachitic Flat Pelvis is spectacularly decreased in this country, surely this should still be taught, when so many midwives will be working abroad after training?

When discussing the foetal skull, caput succedanum is explained, but cephelhaematoma is not. As pupils can get these two conditions confused it seems best to explain both in this context.

This book, with its orderly plan, may well be valuable not only to consultants, but to the midwifery tutor, and to the midwife studying for the Midwife Teachers Diploma. Students would also find the list of diagrams comprehensive.

The book is reasonably priced and contains a comprehensive index.

D.B.

District Nursing with a Difference

continued from page 261

illness may be ferreted out this way, and much public health teaching may be done. The district trip may take up to two weeks, or even longer. On the Labrador just about everything depends on the weather; planes and boats and steamers can all get weather-bound.

Temperatures in winter may fall as low as forty degrees Fahrenheit below zero. This is unusually low, but by no means unknown. The winter starts at the end of September, and spring doesn't usually come till May. In winter mail comes once a week—in theory anyway (that's the weather again!)—by planes landing on skis on the frozen harbours. In summer it is brought by coastal steamer. Supplies also come this way, though the Grenfell Mission has her own small supply boat, which lands all supplies for the various stations once every summer. This means the nurse only has to do her housekeeping once a year, but it is quite a list when the time comes to make it out!

The Grenfell Mission is inter-denominational, and though perhaps no longer a "mission" in the usually accepted religious sense, it is compounded wholly of people willing to go that second mile. In the words of its founder, Sir Wilfred Grenfell, "The lure of the Labrador is not its finished civilisation but its eternal challenge; the challenge to get up and help others, the chivalry of the Christ service".

It is a lure that many find irresistible, a challenge that is still being met.

Aids for the Disabled

Over 100 ingenious new "Aids" to help the disabled towards independence will be shown at an "Aids for the Disabled Exhibition" which the British Red Cross Society is holding at 14 and 15 Grosvenor Crescent, London, S.W.1., on Wednesday and Thursday, 18th and 19th February 1959 from 10 a.m.–7 p.m. for the benefit of the medical and nursing profession.

Many of these simple aids can be made at home for a few pence. For example a coat hanger can be turned into the handle of a long handled comb that will enable an arthritic patient to comb her own hair.

by M. G. WATTS, S.E.A.N.

A Part of The Team

JUST over nine years ago, I was accepted as an S.E.A.N. to help on the district working with the Queen's Sisters. My years of experience have shown me that three things are important:

(1) All S.E.A.Ns. wishing to take part in this branch of nursing must be diplomatic, tactful, very interested in people, thoughtful and must remember at all times that they are guests in the homes of the patients.

(2) S.E.A.Ns. need to be mature, because of the nature of the work and should have had at least five years experience after being accepted on the Roll.

(3) All should have a course in district nursing similar to the one given to me.

I was given this special course after being on the district two years. The difference it made to my attitude to the patient and my co-operation with the sisters, as well as acquiring sound nursing techniques, was amazing.

My working days follow a pattern. After phoning Sister and arranging the cases for the day I set off on my bicycle. All insulin injections to be given first.

Mrs. A. looks rather troubled. She tells me her toe is painful. She had already visited the hospital chiropodist and had an appointment for the following week.

I advised her to go along and see her doctor who would probably make an earlier appointment for her. I wrote her notes accordingly, and told her to take them with her.

I have been visiting Mr. B. and his wife for some years and have therefore heard all their troubles. Mr. B. was a diabetic and Mrs. B. had some obscure abdominal complaint for which she had an operation twenty-eight years ago.

One morning she was so distressed. She asked if I thought the forceps had been left behind. They told her they had left something there!

Keeping a straight face I related the checking and double checking which takes place during and after an operation but advised her to speak to her doctor when next he called.

Mr. C. was quite comfortable and the urine test was satisfactory.

Mrs. D. the next case, was not so well. Her colour was poor and she complained of giddiness and nausea. She had not eaten since 4.30 p.m. the previous day.

I asked the home-help to make some tea and toast. The urine test showed a lot of sugar present. Mrs. D. was not dressed so I advised her to go back to bed. I knew I could not contact Sister. Doctor's surgery was round the corner so I called to see him and explained Mrs. D's condition. He asked me to go back and give the insulin and to see that Mrs. D. had the tea and toast. He would call in later.

Mrs. E., also a diabetic, was very happy this morning. Her son had bought a television set and she was looking forward to many pleasant evenings. Doctor had left a message on her notes to increase the dosage of insulin by two units if sugar still present.

Mrs. F's is an unhappy house. She has a fractured hip and is incontinent. She is living with her daughter and son-in-law. The daughter has a young baby and there is a mentally backward grandson, aged 18 years. One has to be careful not to ' take sides.' Grannie says one thing and the mother the other.

After giving general nursing care and trying to be impartial I left to return to Mrs. D. Doctor had already called. We were told that she had had a visitor to tea the previous day and had indulged in tinned fruit and fancy cakes.

Mrs. G. had a colostomy which she had been taught to deal with herself, but Doctor had ordered saline baths. As she lived alone she had to be supervised.

Mr. H. had a small sinus following an operation for a hernia and a simple dressing was required.

Mr. I., a right hemiplegia, had not been so well during the night and had developed incontinence. His left hip was discoloured. I showed the daughter how to change his position, and as his mouth was dry, to give frequent sips to drink and to use the mouth tray which was set up.

Mrs. J. on Doctor's orders given on the case paper, requested a simple enema owing to constipation. This I gave with satisfactory result.

Later in the afternoon, Sister phoned. I told her about Mrs. D's attack and also about Mr. I.

That evening I gave three weekly blanket baths and then went to put Mr. I. comfortable, thinking that if his condition did not improve it might be necessary to apply to the ' Night Sitter ' Service.

I enjoy my work and somehow in spite of the wind and rain which seem to come so often, I am well. On the second Monday each month we go to the central offices and present our time sheet and visit book for our Superintendent to see. This is when we are able to discuss freely and fully our work and even our personal problems. I get the feeling that I am indeed a part of a team.

I was one of the people who was asked to submit views to the working party on district nursing and the sentiments expressed then, two or three years ago, were those I express now. I hope all S.E.A.Ns. working on the district get the satisfaction in their work that I do.

Have you ideas on the purpose of teaching and the use of techniques? The Institute's Education Officer will be glad to hear them

Training Domiciliary Nurses

by A. BLACK, S.R.N., R.S.C.N., S.C.M., Q.N. & H.V. certs.

ONCE a trained nurse leaves her hospital to work in the homes of the people as a health visitor, district nurse or as a midwife, she finds herself in a world of everyday reality. The glamour, prestige and awe of the hospital are left behind.

Training for domiciliary nursing must prepare the student to become a professional person doing her specialised work but able to enter into the normal life of the community as an interested partner, and this in an atmosphere totally different from the hospital she has left. Many of the familiar supports have gone. She must learn to work very much on her own.

How can we best prepare our student district nurses for this new life in which they are to practise the skills they acquired in hospital for the benefit of patients cared for in their own homes; and to use their unrivalled opportunities for health teaching? Is it by the teaching of good techniques?

The practice of good techniques is necessary in all professions and trades, and district nursing is no exception. Many people including district nurses and their professional colleagues, often think of district nursing techniques as simply the art of adapting hospital skills so that they can be used safely in patients' homes; or of improvising and making use of domestic appliances when hospital equipment is not available.

These points are of great importance. They are tangible things which are easily appreciated; but they are only a small part of the techniques which must be acquired by the student district nurse.

There are two important aspects to be kept in mind constantly. One concerns the practical skills the nurse must use when she is giving any treatment. The other is the art of human relationships.

Most teachers will agree that techniques or good methods must be taught during the short period a student district nurse is in training. Superintendents endeavour to teach techniques in such a way that they can be adapted for use in different types of households, and the student is helped to recognise the underlying principles for these methods. These principles should be considered anew as often as possible:

Practical Skills

It is comparatively easy to consider key points when teaching practical skills.

1. Safety—Each technique must be examined to decide whether the method is entirely safe:
   a. for the patient.
   b. for the family and home where it is carried out.
   c. for the nurse's protection?
2. Is the method really professional, so that anyone seeing the performance recognises that a skilled trained nurse is at work?
3. Is it time saving or will it be when the method is properly learnt?
4. Is the method really practical and can it be used in other surroundings?
5. Has thought been given to the possible use of new materials? If so, have these materials been proved safe, e.g. plastics or new antiseptics?

Human Relationships

These are techniques that are far more difficult to teach; or at any rate, it is difficult to be sure that they have been fully understood. Here, the principles are the need to appreciate the other person's point of view, and to understand as much about his work and living conditions as possible, whether the person is a patient, a patient's relative or a colleague.

The first important thing a district nurse or health visitor student must learn is the attitude she must adopt towards patients and their families when she is a guest in their homes, and not the hostess she was in hospital. This is a fascinating experience for most students, for they will meet so many different types of people in very different social classes.

To many students these new experiences are a great pyschological strain, especially when they meet loneliness, neglect and squalor for the first time. They will need constant help and encouragement in facing these difficulties.

The student also needs teaching and guidance before she is able to work with the general practitioner as a partner, and appreciate all the difficulties he has to cope with. How are we to teach this?

New social legislation including the national health service and national assistance have brought new blessings and also new difficulties. Students must be helped to recognise the patient who is unwilling to accept the rights he is in need of, and one who is far too eager to get what he can from the state.

What methods do we use when teaching our students how much should be done for the patient and family, and when to withdraw and leave them to cope with these themselves?

What about health teaching? District nurses must know the various methods of health teaching. Do we always remember that Miss Nightingale said that a district nurse should always leave the home in a better condition than she found it, and that the teaching she gives should be given without seeming to teach?

It has always been a tradition of the Queen's Institute to encourage individual training centres to develop their own methods, and over many years it is surprising how similar have been the methods evolved in different parts of the country. But it is indeed stimulating to hear from each other of new methods which are being tried and found to be of great advantage. This journal offers an opportunity to individuals to express their own points of view. We would welcome your ideas on the purpose of teaching and use of techniques.

However good techniques are, they are not of importance in themselves, but only because they serve a purpose. Simone Wiel has put this very aptly in 'Gravity and Grace'.

"Precepts are not given for the sake of being practised, but practice is prescribed in order that precepts may be understood. They are scales. One does not play Bach without having done scales, but neither does one play a scale merely for the sake of a scale".

by J. MURIEL RITCHIE, S.R.N., S.C.M., Q.N. cert.

THE CASTLE IN SPAIN

THE window of my first floor room overlooked her front door: a dull brown door standing squarely above four awkward steps. Tall spiky railings surrounded an area basement—a house such as is familiar to every district nurse who has stepped inside a bare hall sensitive as ever to the particular smell of just that particular house.

It was my first summer on that district and I sat by the window occupied with this and that in the hour or so before I began my evening visits. It was the unfailing punctuality of her afternoon walk that interested me. Almost to the minute the door opened and the bent little figure in the black dull coat and the faded mauve hat stepped out. She faced the door as she shut it, then, carefully easing herself down the steps, holding the railings, she began a purposeful little journey down the street.

I watched her several times, vaguely interested in her destination, but curiosity must go unsatisfied in a nurse's uniform and off-duty brought other calls on my time and interest. The little old lady became just a part of a familiar landscape—rather a Hans Anderson fragment of it perhaps, but one which took its place in a daily pattern of manageable if sometimes rather busy routines.

It was several weeks later that a case of bronchitis came on to my books.

" Just general care for a few days, please, nurse," the telephone voice of the doctor said. " It seems overmuch just now for the good soul who sees to her; we all come to it I suppose. Good morning."

NUMBER 14 was a small cottagey sort of a place up a short path, down some small steps. The patient was in the back bedroom. A familiar enough scene it was there too; low deal furniture, a clean chipped jug, " Home by the Ferry " with a small crack in the glass; an antimacassar (wool work) hung on the faded plush armchair, and a wheezing yellowed old woman, clutching life weakly, was propped in the double bed. A faint mellow liquoricy smell hung thinly everywhere.

As I began the nursing a cat wandered vaguely across the tidy backyard outside the window. The washing in the next garden flapped wetly. The old woman had been turning the pages of a thick catalogue as I went in. I mentioned it as I sponged and tidied her, replaiting her thin, though not ill-kept, hair and contending with the delicate business of dentures.

" We often furnish from it," she said lovingly, with a glance at the stiffly heavy volume. " The Army and Navy Stores " with a date of nearly twenty-four years before, said the title page. " Lovely things we choose out of it sometimes," the old woman said contentedly.

" Gramophones? " I said vaguely, memories of one with a large wooden horn playing " Custer's Last Charge," and a cheerful talkative recital called " Mrs. Kelly " on the reverse side, popping out of a side door in my memory.

"We like a *harmonium*," the old woman said courteously, "and the *square* kind of organ stool."

"The round kind spins nicely," I observed, and we both surveyed silently our own respective memorial corridors in which these things were stacked reminiscently.

"Goodbye, nurse, come again," she said as I left her, making nonsense of such things as Working Party reports and Health Acts!

I visited her regularly for some time. Another house, paper-thin and Army and Navy deep, grew steadily into an airy floating world behind the mundane one of washing and bed-making. All the time I called there the little house and its frail owner were kept in cheerful heart and clean ways by someone called Jennie.

Jennie came and went between my visits, leaving the ups and downs of little imaginary plans behind her in cheerful inconsequence. For instance, "A change of curtains in the pink room —the eight and fourpenny, *with* beading."

An imaginary bookcase (glass-fronted and in mahogany) was added at my suggestion as November gales blew yellow discarded leaves, sodden and clinging, against the window panes. Discussion of the books with which we should fill it occupied a full five visits (now reduced to twice-weekly "essential wash" visits; Jennie managed well on the other days).

The "Army and Navy" was generous with book titles, *The Chaplet of Pearls* and *The Secret Garden* rubbed shoulders with the sociable company of *Mary Francis' Knitting and Crotchet Book*. The original of this yellowy volume had patterns gummed in fragile papery dignity between its pages. The old woman crotcheted admirably. We added the book to the 'Spanish Castle' for its pictures and for the pleasantness of its enthusiasms.

Autumn left us and winter advanced. After Christmas I went on my holiday. My relief nurse handed me the lists on the morning of my return. "The companion's been away too," she said, when we reached the record of No. 14.

"And, by-the-way," she added as we parted outside my door, "a poor soul was found crumpled up quite dead behind a door—Dr. S. was sent for. Coronary or something, I suppose, or so one hopes. It's the house almost opposite."

Before I looked up I knew suddenly from which door the cheerless little funeral party would emerge, and on which windows the inadequate white curtains were even then keeping watch and ward.

At No. 14 signs of near-chaos were becoming visible.

"Do you think she will come back soon, nurse?" the patient insisted. "It's my little comforts she sees to between your visits . . . ."

I shook my head in answer to her foreboding. "Give me her name and address," I said, "and I'll call there on my way home."

"I'll pick out some new lights," she said eagerly as I got out my notebook.

"I think," I said suddenly, warding off the "postage-stamp regret" which was penning me realistically, "I think your little old friend has got her own lights with her."

Then, hands folded, she spelt out, clearly and sweetly, an address in my own street, which I knew well had a brown front door and four awkward steps. . . .

When I got home there was no sign of the tiny funeral procession which had edged unimportantly out of the end of the street an hour before. By the end of the day, though, new curtains had appeared in the upstairs windows there; newspapers, pinned across those on the ground floor, heralded spring-cleaning within. Someone I suppose, was anticipating a new lodger. . . . .

EDUCATIONAL OPPORTUNITIES FOR NURSES

BETTER preparation for nursing leaders will help the community by improving health, promoting the prevention of disease, and aiding rehabilitation.

The International Council of Nurses has published a *Supplement* to the original publication *An International List of Advanced Programmes in Nursing Education*. In this *List* and its *Supplement*, programmes of advanced preparation for nurses are listed according to country, town, type of programme, etc.

Considerable changes have taken place in post-basic nursing programmes since the original *List* appeared.

With today's emphasis on international co-operation, an up-to-date list of the world-wide educational opportunities for nurses is certain to be useful. It will be of assistance to nursing students wishing to obtain full information about post-basic programmes in other countries as well as their own. It is hoped that it will also be of use to schools of nursing, reference libraries, scholarship agencies, international organisations, and other organisations concerned with education for nurses.

The *Supplement* can only be read in conjunction with the original *List*. The *List* and *Supplement* can be obtained from the International Council of Nurses, 1 Dean Trench Street, Westminster, London, S.W.1., England, at a price of 21*s*. The *Supplement* only (for those who have previously purchased the *List*) can be obtained at a price of 5*s*.

The Association of Queen's Nurses

An Appeal from the President

Dear Colleagues,

You will know that this year is the Centenary of district nursing and each of you will have received a letter from the Chairman of the Appeal Committee.

Numerous plans, both to celebrate the Centenary and to raise money, are being made and we need your practical help and suggestions.

The Association of Queen's Nurses in the London area is arranging to hold a garden party and sale of work in the early summer and on page 256 you will see that a centenary cookery book is being compiled, for which well-tried and original recipes are required.

Other branches of the Association of Queen's Nurses will be organising fund-raising events, but I should like to make a special appeal to *all* district nurses, both at home and abroad, to make individual efforts to mark this Centenary Year, thus ensuring the continuance and expansion of our work.

Yours sincerely,

L. Joan Gray

The first of a series on health aspects of atomic energy as discussed at the United Nations Geneva Conference

Disposal of Radioactive Waste

by RITCHIE CALDER, C.B.E.

IN the drowned landscape beneath the oceans there are great valleys, in comparison with which the Grand Canyon of Colorado, a mile deep, 200 miles long, is not so very grand. Nineteen ocean " trenches " are over four and a half miles deep and some are thousands of miles long. In the search for " burial grounds " for the disposal of radioactive wastes, which may become a problem when the atomic industry develops on a world-wide scale, those " trenches " seemed likely places. It was assumed that they were troughs of stagnant water. There, so the argument went, the dangerous elements, in their concrete metal coffins, would lie undisturbed for centuries until their radioactivity was spent.

This glib assumption was questioned three years ago at the first International Conference on the Peaceful Uses of Atomic Energy. At the second meeting in Geneva the illusion was finally dispelled.

In the intervening years the Russian ship " Vityaz " carried out oceanographic investigations of twelve of these trenches. The findings of the expedition have shown that the trenches are unsuitable places for the disposal of radioactive waste.

Biological elevator

At the conference, Dr. E. M. Kreps (U.S.S.R.) reported in detail on the Tonga Trench, which extends southwards for nearly 700 miles from the Samoa Islands to the Kermadec Islands. The Russian expedition found that, by comparison with the findings of the " Galatea " expedition in 1952, the deep water temperature had risen. This showed that even at the greatest depth a change of water takes place in as brief a space as five years. The distribution of oxygen and phosphates and the presence of living organisms consuming oxygen at every depth showed that the water was actively mixing, horizontally and vertically.

This means that the dangerous materials with long-lived radioactivity will be liable to break loose and escape upwards into the upper layers of water. There marine life would become radioactively infected and form a biological chain reaction which would end up in the food of human beings.

This warning was reinforced, at the conference, by Dr. B. H. Ketchum, of the Woods Hole Oceanographic Institution. He showed that there was a kind of biological elevator in the sea which would bring radioactive materials from the deeps to the surface. Sea organisms, he showed, concentrated the fission products so that the plankton in the Bikini test area of the Pacific had 470 times more radioactivity than the water itself.

In life, the marine organisms would pick up, concentrate, and transfer the radioactivity from the contaminated layers of the ocean to the uncontaminated. In death, the organisms would sink towards the bottom and the fission products, bound up in their skeletons, would increase the radioactivity in the depths. Thus there would be an upward and downward movement of radioactivity, apart from any mixing of the upper and lower waters. This drastically changes the picture which assumed that the transfer between the deeps and the surface would take about 300 years.

No cause for alarm

Both Britain and America have been dumping radioactive materials in the Atlantic trenches but of a kind and on a scale which so far gives no cause for concern. The British explained that the only materials they had so far deposited were contaminated machinery from Harwell, of a shape which made it awkward for storing them in the safety tanks in which long-lived fission products are kept. The total amount of radioactivity deposited in eight years in the deeps, by the British, amounted to about 600 curies, an insignificant amount in dilution. The Americans have carried out regular surveys of their " ocean graveyards " and have found no evidence of any increase in the radioactivity of the water.

The disposal of radioactive liquid wastes in coastal waters is another matter. The British have had a long experience of disposing of this kind of " sewage " from their atom factory at Windscale in Cumberland. A pipeline carried the effluent two miles beyond high water mark into the Irish Sea. This is very mild radioactivity, since the main fission product wastes are concentrated and stored inland. The discharging into the sea is carried out under strict supervision of government inspectors and under public health regulations already established.

To inspection at source, is added strict and continual hydrographic and biological surveys of the sea and the shoreline. As part of this programme, over 35,000 fish were caught and marked and some recaught under a planned fishing programme. These, like the edible seaweed and the sands of the shore, have given little indication whatever of any increase in radioactivity which might cause concern.

The Russians at the conference took a very strong line that no radioactivity of any kind should be disposed of in open waters, or on land, under any conditions in which it might seep into the ground water. They reported that even their mild effluent is run into concrete ditches and sealed off by concrete.

Tank storage safest

What was made abundantly and consistently clear was that the disposal of waste so far has not been on a scale, nor in circumstances, which constitute a present public health hazard. The insistence of the many technical papers presented on this subject was on the precautions necessary for the future. What was emphasized was that a great deal more research must be done before any kind of " dumping " could be tolerated.

The only safe method of storage is in tanks in which the radioactive substances are allowed to decay—and some of them will take centuries to do so. To the complications of storage is added the fact that in giving off their radiation the elements are producing heat which, in given circumstances, will cause the tanks to boil—and go on boiling for 100 years.

And, of course, there is always the risk, even in peaceful uses, of an accident. Again, experience so far has been reassuring. The atomic energy industry, already employing hundreds of thousands of people, is, on its record, the safest of all industries. Its accident rate, even in terms of non-radioactive accidents, is the lowest of any industry—because the preoccupation with the new kind of hazards has increased the precautions against the old kind of hazards.

The most serious accident so far has been the " burn-out " of the British reactor at the Windscale plutonium factory. There were no casualties and no one suffered ill-effects.

Public health lesson

But it demonstrated a public health risk. The reactors at Windscale which had been operating since 1950 are air-cooled. Cooling air is drawn through filters from the atmosphere and then blown through the reactor core. The exhaust air is passed through a bank of filters mounted at the top of a stack 410 feet high. On the occasion of the accident these filters trapped the larger particles from the damaged reactor but finer particles and gases escaped.

At the Geneva conference a detailed account was given, which will become a text book lesson for public health authorities everywhere. It included an exact record of meteorological conditions, and of the " flying squads " of radiation experts who toured the area examining the herbage, the oil and, eventually, the milk. The milk revealed the presence of radioactive iodine and the milk from farms over an area of 200 square miles was banned from use. Vegetables, eggs, meat and drinking water were also monitored but no contamination was found which would constitute a hazard. Adults and children were examined to discover if any radioiodine had been ingested and had found its way to the thyroid gland. No results were found to cause dismay.

The survey was extended to Southern Scotland, Yorkshire, Lancashire, Westmorland and North Wales and later samples of milk were collected from the Isle of Man, Northern Ireland and the South of Scotland. The outcome of these immediate and also long-term studies showed no significant deposition of radioactivity other than radioactive iodine. For the physicists and engineers the accident emphasized the precautionary measures needed in design and in control of reactors. For the public health authorities it was an alarming but salutary experience which will be turned to account in legislation and in practice as atomic power stations develop not only in Britain but throughout the world.

International control

It underlined the appeal made by the Netherlands Royal Academy of Sciences to the conference for international measures to control the radiation risks. As Professor J. H. de Boer, the spokesman for the Academy, emphasized at the final session of the conference, radioactivity knows no frontiers. The hazards are particularly serious in Western Europe with its dense population and great industrial activity presently to be increased by atomic power reactors. He pointed out that the siting of reactors might be a hazard to neighbouring countries and that there must be international agreement about their location. He cited the " stationary sources of danger "—all types of reactors, fuel reprocessing plants, stores of radioactive waste and industries increasingly using radioisotopes. But he also cited mobile sources—atom-driven ships and possibly, later, aircraft; and the transport of radioactive materials by sea, air and land.

The radioactive material might cross territorial frontiers in the atmosphere, the waters of the oceans, rivers, lakes, canals, etc., and by actual transport. While insisting that the problem for Western Europe is more urgent than for any other part of the world he, on behalf of the Royal Netherlands Academy, appealed for international regulation of radioactive hazards.

As a measure of the problem, consider that the United States in fourteen years has accumulated 60,000,000 gallons of radioactive elements stored in more than a hundred indestructible steel tanks. The cost so far has been 65,000,000 dollars. Some of the elements will remain dangerous for decades, others for centuries and, in the case of plutonium, for at least 24,000 years.

Forty-two years from now—on the estimates of the world's use of peaceful atomic power for 2000 A.D.—the amount of waste will require 100,000 acres a year as " burial grounds "—that is, if they use the most compact methods of disposal—like fusing the fission products in glass.

As the chairman of one of the sessions commented, " The tombs of radioactive waste are becoming as elaborate and expensive as those for the mummies of the Pharaohs."

correspondence

Broken Service

IT is with deep regret I have learned, after the stable door has been closed on the proverbial "horse," I am no longer eligible for full time employment as a district nurse with my local council. My superannuation is not in order!

These last six words constantly echo in my head. At the age of 43 years I am one of the "unwanted."

Due to broken service, because of war service and domestic reasons, I now fail to qualify for full employment, not because of unsatisfactory qualifications or character, but for the sole reason that I have more than five years broken service and I am classed as a liability. My error was to withdraw my contributions from the Local Government Superannuation Fund in 1942.

There must be many cases similar to my own all over the country. Individually we can do little about it. Collectively we may be able to present our case to the Minister concerned and urge him to understand the position we are in, not by our own fault, but by ignorance of facts in the past.

I feel sure that once the facts are put before them, the Government will realise our dilemma, and allow our respective councils to employ us on a full time basis. None of us feel we want to be a liability. The Act of Parliament concerning the Local Government Superannuation Fund should be overhauled, and a compromise found whereby we can once again be accepted into the superannuation scheme.

There is a heartfelt want for trained district nurses, and all we ask is to be allowed to do a full day's work, attending the sick and aged who need and respect us.

May I please request all nurses who are in a similar position to myself to contact me, for I hope as a representative body we may restore our rightful status as full time nurses.

M. M. Probst (Mrs.),
S.R.N., S.C.M., Q.N. Cert.

6 Keynes Road,
Cricklewood,
London, N.W.2

Letters should be addressed to: The Editor, District Nursing, 57 Lower Belgrave Street, London, S.W.1.

Home from Abroad

FIVE Queen's nurses who have recently returned to this country after doing pioneer work overseas, were the guests of honour at a buffet luncheon held at the Queen's Institute last month.

Members of the Institute's general executive committee and overseas subcommittee were present to welcome their guests and to hear at first-hand some of their experiences.

The most recently returned was **Miss Rosalie Hunt,** after two years with the Hyacinth Lightbourne Visiting Nursing Service in Jamaica. With the help of one Queen's-trained Jamaican nurse, Miss Hunt started district nursing in Kingston in February 1957. There are now seven Queen's-trained Jamaican nurses working in Kingston and one country district.

Miss Miriam Sankey set up and ran the first training course for public health nurses in Singapore. Originally intended as a district nurse/health visitor course, it eventually became a course for health visitors only. The students were of several nationalities and of widely differing backgrounds.

Miss Dorothy Goodwin, a former Education Officer of the Institute, has spent the past four years as the first Public Health Nurse Tutor at University College Hospital, Ibadan, Nigeria.

Miss Goodwin will shortly be flying to Singapore, where she has been appointed to succeed Miss Sankey.

No stranger to the tropics, **Miss Iris Irven** misses the warmth of Kenya, where for the last two years she has worked as a public health nurse in an up-country district. Her story appeared in our December issue.

Miss Mary Cuzner has been superintendent of the Malta Memorial District Nursing Association since 1954. During this time the service has expanded and it now includes the Island of Gozo, where the first district nurse/midwife/health visitor was appointed in 1955.

Although Miss Cuzner does not officially leave Malta until April, she managed to attend the luncheon as she had flown to this country to bring a sick child to Great Ormond Street.

obituary

Miss A. M. Dalton

HER many friends and colleagues will be distressed to learn of the death on 20th January, of Miss Amy Margaret Dalton. After training at Mill Road Infirmary, Liverpool, Springfield Maternity Home and Blackburn D.N.A. she held posts as staff midwife and midwifery sister at Preston, Liverpool and Penrith.

In 1958 she undertook Queen's training at the Liverpool Queen Victoria D.N.A. and was appointed district nurse/midwife in Cumberland in May. For her patients she was always ready to do that little extra which makes all the difference to comfort.

Miss Jones was a very active member of the Old Queen's Nurses League and the Association of Queen's Nurses and served for several years on the Council of the Queen's Institute as a representative. She was also the secretary of the Cheshire Branch of the Association.

Miss A. M. Jones

IT is with regret that we report the death of Miss Ada Mary Jones, who died recently after a long illness which she bore with great fortitude.

Miss Jones took her general training at Rochdale Infirmary 1934–1937, the midwifery training at the Maternity and Women's Hospital, Glasgow 1937–38. Her Queen's district training was taken at Liverpool North Home in 1939. She worked as a Queen's district nurse/Midwife at Cefn Mawr from 1939 to 1942, when she went to Barnston, Cheshire, where she worked until her death.

Miss Jones was greatly appreciated by her medical and nursing colleagues.

Miss I. M. Wells

WE regret to announce the death of Miss Irene Mary Wells who until recently was Superintendent of the district nursing centre at Selly Oak, Birmingham. Miss Wells trained at the General Hospital in Birmingham; she took her midwifery training in Cheltenham and Queen's Training at the Bordesley Centre, Birmingham, where she later became an Assistant Superintendent. Miss Wells was appointed Superintendent of the district nursing centre at Selly Oak in 1945. Under her enthusiasm and administrative skill the service developed and expanded.

Miss Wells had a friendly and sympathetic personality and she endeared herself to all. She worked unsparingly on behalf of her Church and professional organisations.

Queen's Nurses

Personnel changes from 1st to 31st December, 1958

APPOINTMENTS

Superintendents, etc.

Bazley, E. M., Jersey (Supt. Nursing Officer). Fyles, D. O. (Mrs.), St. Helens (2nd Asst. Supt.). Mullavill, M. T., Birmingham (Dep. Supt.).

Nurses

Broadest, A. (Mr.), Hants. Chapman, O. (Mrs.), Cheshire. Gattrall, R. Y., Hants. Howarth, W. E., St. Helens. Hughes, J., Norfolk. Jones, G. F., Rotherham. King, I. M., Swansea. Knowles, E., W. Riding. Lacey, K. E., Somerset. Lebbell, E., Norfolk. Marks, G. (Mrs.), Westmorland. Martin, M., Worcs. Morris, G. M., W. Sussex. Naunton, M. (Mrs.), Herts. Perks, M. E., Kent. Prior, E. A., W. Sussex. Reeve, I. C., W. Sussex. Rogers, L. K., W. Sussex. Schofield, V. J., Oxon. Walker, J., Norfolk.

RESIGNATIONS

Downes, H. M., Worcester—Retirement. Ambrose, B. L., Essex—Other work. Ankrett, M. (Mrs.), Warws.—Domestic reasons. Bachelor, J. H. (Mrs.), Leeds—Marriage. Bates, E., W. Sussex—Retirement. Bays, R. G. M. (Mrs.), Hunts.—Domestic reasons. Bond, K. J., Dorset—Retirement. Boulton, J. (Mrs.), Lancs.—Domestic reasons. Collington, M. O. A., Worcs.—Retirement. Cooper, E. (Mr.), Hants.—Other work. Crank, E. A., Cheshire—Marriage. Crawley, P., Hants.—Retirement. Cummings, E. (Mrs.), Lancs—Other work. Dicker, E. M. (Mrs.), Birmingham—Domestic reasons. Fairhurst, W., Preston—Health reasons. Flexman, J. V., St. Olaves—Hosp. theatre course. Hardy, M., St. Helens—Hosp. course. Harte, S. J., Lancs.—Retirement. Haylor, H. M., Warws.—H.V. post. Holland, F., Reading—Midwifery post. James, R. B. (Mr.), Halifax—To manage own nursing home. Jarman, C. M., St. Helens—Hosp. course. King, R. T. (Mr.), Worcester—Hosp. post. Leigh, E. (Mrs.), Westmorland—Domestic reasons. Loughlin, M., Preston Domestic reasons. McDonald, E., Hackney—Return to Jamaica. Maskell, D. E., W. Sussex—Retirement. Metcalfe, M., Westmorland—Other work. Mitchell, M. M. (Mr.), Warws.—Domestic reasons. Morris, T. E. A., Hackney—Return to Jamaica. Murray, J., Middlesbrough—Midwifery post. Oakham, B. (Mrs.), Surrey—Personal reasons. Parr, B., Middlesbrough—Health reasons. Priest, N., Cheshire—Retirement. Robson, A., Middlesbrough—Marriage. Roche, T. (Mrs.), Birmingham—Domestic reasons. Stredder, I., Lancs.—Retirement. Thomas, L. (Mrs.), Cambs.—Retirement. Vose, M. P. (Mrs.), Lancs.—Domestic reasons. Wardle, E. F. (Mrs.), Worcester—Domestic reasons. Wood, E. M. (Mrs.), Plymouth—Domestic reasons.

LEAVE OF ABSENCE

Humphrey, A. E.—Personal reasons (Asst. Supt.). Gethen, M. A.—Home reasons. Jones, G. F.—Midwifery trg. Lane, M. C.—H.V. trg. Pielow, S. M.—H.V. trg. Welch, B. N. (Mrs.)—Domestic reasons.

REJOINERS

Beaty, B. D., Birmingham. Brockway, V. D., Exeter (Asst. Supt.). Brown, I. L., Warws. Bullen, M. M. (Mrs.), Notts. Clohessy, M. M. (Mrs.), Rugby. Crouch, N. M. B. (Mrs.), Somerset. Furneaux, N. A. (Mrs.), Flints. Green, L. M., Warws. Hoath, E. M., Birkenhead. Howard, J. R. N., Bournemouth. Phillips, H., Blackburn. Richards, P. M. (Mrs.), Bristol. Snell, G. V., Devon. Tallett, H. (Mrs.), W. Riding. Walpole, M. G., Norfolk.

SECONDMENT

Irven, I. D.—Work with S.S.A.F.A. Spears, G. M.—Midwifery teacher in India with W.H.O.

SCOTTISH BRANCH

APPOINTMENTS

Nurses

Brown, J. B., Lybster. Ferrier, M. J., Kilsyth. Graham, Jessie, Evanton. Hopkins, M. L., Kingussie. Mackay, Christina, Stornoway Burgh. MacSween, M. K., Ayrshire—C.R.N. Paterson, M. M., Airth. Willison, A. M., Quarter.

REJOINERS

Campbell, M. D. (Mrs.), Luing. Hayworth, E. G. (Mrs.), Millerston.

RESIGNATIONS

Bain, J. W., Blackhall—Other work. Campbell, F. B., Eddrachilles—Marriage. Cox, B. S. P., Monifieth—Other work. Coyle, B. T., Edinburgh—Work abroad. Hardie, M. A., Bridge of Don—Marriage. McIver, C. M., Rutherglen—Other work. McKirdy, C. R., Glasgow (Dennistoun)—Other work. McLeod, A. H., Auchinleck—Home reasons. Paton, I. C. G., Quarter—Marriage. Sinclair, H. (Mrs.), Millerston—Retired.

Windsor, Slough and Eton Express

Thanks A Thousand Times

A BOOK containing the signatures of more than a thousand grateful patients who contributed towards the farewell gift, was presented with a cheque to Miss Dora Quartermain by Dr. Maxwell Summers (above), when she retired as district nurse, Cippenham, Berks.

Miss Quartermain began nursing at the Central Middlesex Hospital forty-nine years ago. She has been a Queen's Nurse for thirty-five years, and was at one time a training home superintendent.

"Hardly anyone in Cippenham", says the *Windsor, Slough and Eton Express*, "can be better known or loved than Miss Quartermain. For nearly twenty years she has been delivering babies and tending the district's sick."

CLASSIFIED ADVERTISEMENTS

Advertisements for this section can be received up to first post on the 2nd of the month for publication on the 10th. They should be sent direct to: District Nursing, 57 Lower Belgrave Street, London, S.W.1. Telephone Sloane 0355.
Rates: Personal, 2½d. per word (minimum 12 words, 2s. 6d.): all other sections, 3d. per word (minimum, 12 words 3s.)
Displayed Setting: 17s. 6d. per single column inch.

QUEEN'S INSTITUTE OF DISTRICT NURSING SCOTTISH BRANCH

The Scottish Council of the Institute invite applications from Queen's Nurses, with administrative experience, for the post of **Superintendent of the Scottish Branch.**

The post is superannuable.

Furnished flat available for which a deduction will be made from salary.

Applications, marked "Confidential", and giving the names of two referees, to be received on or before 7th March 1959, should be addressed to : The Secretary, 26 Castle Terrace, Edinburgh 1.

NORFOLK COUNTY COUNCIL

Applications are invited for vacancies in the undermentioned areas:—

District Nurse/Midwife/Health Visitor (preferably with Queen's and H.V. Certificate or willing to train)

Aldeby, Nr. Beccles. Unfurnished house.

Barnham Broom, Nr. Norwich. Unfurnished house.

Burnham Market, North Norfolk. Unfurnished house.

Castle Rising and **Hillington,** Nr. King's Lynn. Two nurses (friends) required for double district. Unfurnished bungalow at Flitcham.

East Harling, Nr. Thetford. Unfurnished house.

Dersingham (Sandringham Estate). Furnished or unfurnished house.

Hilgay, Nr. Downham Market. Unfurnished house.

Hockham, Nr. Thetford. Unfurnished house.

Long Stratton, South Norfolk. Second nurse. Furnished accommodation.

Oulton, Nr. Aylsham. Unfurnished house.

Tilney, Nr. King's Lynn. Unfurnished house.

Terrington St. John, Nr. King's Lynn. Furnished accommodation—house later.

District Nurse/Midwife (preferably with Queen's Certificate or willing to train).

Fakenham. Increase of staff. One of three nurses living separately. Furnished accommodation.

Wroxham. Unfurnished house.

Full-time Midwife (S.R.N., S.C.M., and preferably with Queen's Certificate).

East Dereham. Unfurnished house.

Watton. Furnished accommodation—House being built.

Facilities available for Health Visitor and Queen's Nurse training with a view to generalised duties.

Staff needed for relief duties—holidays or longer periods.

Whitley Council salaries and conditions of service.

Successful applicants can use their own cars (loans available for purchase) or cars can be provided. Consideration will also be given to supplying furniture, if required.

Application forms from County Medical Officer, 29 Thorpe Road, Norwich.

WARWICKSHIRE COUNTY COUNCIL

Applications are invited for the following vacancies. Where houses or other accommodation available, this can be either furnished or unfurnished. Charges in accordance with the Whitley Council recommendation. Consideration will be given to the granting of financial assistance towards removal expenses.

District Nurses—District Midwives—District Nurse/Midwives

Area 1 **Sutton Coldfield** (urban) district midwife or nurse/midwife—motorist—house.

Area 2 **Ansley** (rural) district nurse/midwife—motorist—house. **Bulkington** (urban and rural) district nurse/midwife—motorist—house. **Nuneaton** (town) district nurse—motorist—bed-sitting-room.

Area 3 **Rugby** (town) district nurse or nurse/midwife—motorist—flat (building commenced).

Area 4 **Balsall Common** (rural) district nurse/midwife—motorist—modern house. **Castle Bromich** (urban) district nurse/midwife—motorist—flat (building commenced). **Coleshill** (urban) district nurse or district nurse/midwife—motorist—flat.

Area 6 **Lapworth** (rural) district nurse/midwife—motorist—house. **Leamington Spa** (town) (*a*) district nurse/midwife—motorist—part house; (*b*) district midwife—motorist—part house. **Warwick** (small town) district nurse/midwife—motorist—bed-sitting-room.

Area 7 **Temple Grafton** (rural) district nurse/midwife—motorist—house.

District Nurse/Midwife/Health Visitors

Area 4 **Berkswell** (rural) one required—motorist—part house. **Meriden** (rural) one required—motorist—flat.

Area 6 **Fenny Compton** (rural) two required—motorist—suitable friends willing to share house.

Health Visitors

Area 1 **Sutton Coldfield** (urban) one required—motorist.

Area 2 **Polesworth** (rural) one required—motorist—flat.

Motorists can receive allowance for own car or car will be provided.

Application forms and full particulars may be obtained from the Area Medical Officer as follows:—

Area 1—Health Department, Council House, Sutton Coldfield. Area 2—Health Department, Council House, Nuneaton. Area 3—Health Department, Albert House, Albert Street, Rugby. Area 4—Health Department, Park Road, Coleshill. Area 6—Health Department, 38 Holly Walk, Leamington Spa. Area 7—Health Department, Arden Street, Stratford-upon-Avon.

The Council is a member of the Queen's Institute of District Nursing

Shire Hall, Warwick — L. Edgar Stephens, Clerk of the Council

CUMBERLAND COUNTY COUNCIL
(Affiliated to the Queen's Institute of District Nursing)

District Midwife for Whitehaven (S.R.N., S.C.M., and/or Q.N.). One required. Accommodation to be arranged. Car provided.

Health Visitor for Workington (S.R.N., S.C.M., H.V. Cert.). One of four. Car provided.

District Nurse/Midwives (S.R.N., S.C.M., Q.N.) for

(*a*) **Millom**—Double district. One vacancy. Applicant willing to take district training considered. Accommodation to be arranged. Car provided.

(*b*) **Egremont**—Double district. Further vacancy later if friends interested. Furnished house provided. Car provided.

Application forms obtainable from the County Medical Officer, 11 Portland Square Carlisle.

WESTMORLAND COUNTY COUNCIL NURSING SERVICES

Burneside, near Kendal. District nurse/midwife/health visitor required for combined duties. Health Visitor's Certificate desirable. House and car provided or payment according to N.J.C. recommendations for use of own car.

Apply: County Medical Officer, County Hall, Kendal.

CITY OF YORK DISTRICT NURSING SERVICE

Applications are invited for the appointment of district nurse in the City of York. Preference will be given to members of the Queen's Institute or to candidates willing to train.

Whitley Council Salary and conditions of service.

Applications, stating age, qualifications and experiences, together with the names of two referees, to be forwarded to the Medical Officer of Health, 9 St. Leonard's Place, York.

KENSINGTON DISTRICT NURSING ASSOCIATION

Training Centre for Queen's Nurses.

Applications are invited for the post of Superintendent, S.R.N., S.C.M., H.V., Q.N. Certificates. Staff approximately 30 including two Assistant Superintendents. Study Day method of teaching. Comfortable well equipped home. Car provided or allowance to car owner. Housekeeper employed.

KENSINGTON DISTRICT NURSING ASSOCIATION

First Assistant Superintendent required H.V. certificate. Good experience in teaching and in general administration. Staff approximately 30. Comfortable modern home—housekeeper employed.

Other Advertisements on p. 272

HEREFORDSHIRE COUNTY COUNCIL
Health Visitors Training Course

Scholarships are offered for health visitor's training or combined health visitor/Queen's district training courses commencing September, 1959, at recognised training centres. Grant during training of 75% of minimum of health visitor's salary scale plus tuition and examination fees. Candidates required to undertake generalised or full time health visitor duties in the County upon completion of training.

Hereford City

Health Visitors. Two required for full-time health visitor/school nurse duties.

District Nurse/Midwives. Two required for combined duties. Would suit two friends: normally off duty together. Good accommodation, furnished or unfurnished. Cyclists or motorists—car provided.

Rural Districts

District Nurse/Midwives preferably with Queen's and health visitor's certificates, or willing to train. Generalised duties. Motorists—cars provided or allowances for own cars. Houses, furnished or unfurnished. Suit two friends, normally off duty together.

Kingsland I and Pembridge—(Kington/Leominster area).

Lugwardine and Stoke Edith—(Hereford/Ledbury area).

Application forms and terms of appointment may be obtained from the County Medical Officer, 35 Bridge Street, Hereford.

LIVERPOOL QUEEN VICTORIA DISTRICT NURSING ASSOCIATION

State Registered Nurses required for Queen's Training, resident and non-resident.

There are vacancies for the courses which are to be given in March, May, July and September 1959. Nurses may take up duties before these dates.

Applications also invited for the posts of full-time District Nurses. Preference will be given to Nurses with Queen's District Training.

Apply: Senior Superintendent of Home Nursing, 1 Princes Road, Liverpool 8.

COUNTY OF RADNOR

Two district nurse/midwives required for rural areas. Cars can be provided.

Apply: Miss Todd, Superintendent Nursing Officer, County Hall, Llandrindod Wells.

HASTINGS DISTRICT NURSING ASSOCIATION

Staff Midwife full-time required. Resident or non-resident. The Home is run in conjunction with the District Nursing Association as Part II School.

Apply to Matron, Fernbank Maternity Home, Old London Road, Hastings.

ISLE OF ELY COUNTY NURSING ASSOCIATION

Wisbech—market town.

Two full-time district midwives with or without Queen's district training.

Chatteris—small market town, near March. Two district nurse/midwives. Queen's or non-Queen's (one or both with H.V. Certificate desirable).

Would suit friends. Furnished or unfurnished houses available on both districts. Consideration will be given to the granting of financial assistance towards the removal expenses. Motorists or willing to learn, help given with driving tuition.

Further details and application forms can be obtained from the Superintendent Nursing Officer, County Hall, March, Cambs.

ST. HELENS DISTRICT NURSING ASSOCIATION

First Assistant Superintendent required. H.V. Certificate preferred. Post provides experience in general administration and in the training of Student District Nurses. Motorist or willing to learn. Accommodation provided in comfortable well equipped home.

Apply: Dep. Gen. Supt., Q.I.D.N., 57 Lower Belgrave Street, London, S.W.1.

Sister required for Catholic Mother and Baby Home outskirts London. Person appointed will be required deputise for Matron. An interest in social work would be desirable. Post might suit nurse near retirement. Comfortable home and large garden. Good conditions.

Apply with full particulars and two names for reference. Box No. L.1.

CITY OF OXFORD DISTRICT NURSING SERVICE

Two Queen's nurses required for small branch home. General nursing only. Furnished house, domestic help provided. Preferably motorists. Suit friends.

Apply: Superintendent, 39 Banbury Road, Oxford.

CROYDON DISTRICT NURSING ASSOCIATION

Deputy Superintendent required for February 1959. Training Home for Queen's nurses. Staff 46–50. General Nursing only. Previous experience and Health Visitor's Certificate essential. Allowance forown car. Non resident—unfurnished flat available.

MIDDLESEX COUNTY COUNCIL

Deputy matron (res.) S.C.M. initially at Red Gables Mother and Baby Home, Hornsey. (16 unsupported mothers and their babies.) Salary £530–£667 p.a. less £173 p.a. for board and lodging. Established, pensionable, subject to medical assessment and prescribed conditions.

Full particulars and two referees to County Medical Officer, Ref. 'S', 3, 5 and 7 Old Queen Street, London, S.W.1. by 16th February. (Quote Z.21. D.N.J.)

WARWICKSHIRE COUNTY COUNCIL
Health Visitors Training

Applications are invited from State registered nurses holding Part One of the C.M.B. certificate, to take health visitors training. Vacancies for September 1959. Training grant at the rate of 65% of the minimum salary for qualified health visitors (present grant approximately £6 18*s* per week) from the commencement of training to the final examination. Interview expenses, tuition fees and examination fees paid, and certain items of uniform provided. Salary on health visitors' scale on passing examination.

Application form and further particulars can be obtained from the County Medical Officer of Health at Shire Hall, Warwick.

L. Edgar Stephens, Clerk of the Council

SOMERSET COUNTY COUNCIL
Health Visitor's Scholarships

The Somerset County Council offers scholarships at approved training schools in preparation for the Health Visitors' Examination of the Royal Society for the Promotion of Health. Candidates must be S.R.N., S.C.M., and preference will be given to nurses with Queen's District Training.

Tuition fees and first examination fees are paid by the County Council. During training students receive an allowance at the rate of three quarters of the minimum salary of a qualified Health Visitor.

Full particulars and application forms can be obtained from The County Medical Officer of Health, County Hall, Taunton.

QUEEN'S NURSES' BENEVOLENT FUND

Founded in 1913 by Queen's Nurses for Queen's Nurses

Minimum subscription FIVE SHILLINGS a year.

OBJECT—To assist financially colleagues who have to give up work owing to illness.

APPLICATIONS for financial assistance may be made for a GRANT, after three consecutive subscriptions previous to going off duty owing to an illness of short duration have been paid, and after salary rights have been exhausted.

OR

AN ANNUITY, after five consecutive subscriptions have been paid up to time of going off duty, when the illness involves resignation from district nursing, and the applicant is unable to undertake other work.

SUBSCRIPTIONS should be sent to Miss Ivett, Lancastria, Boydon Road, Maidenhead, Berks, from whom further details can be obtained.

An Annual Report, with a renewal notice, is posted direct to all subscribers each year.

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